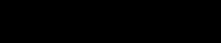
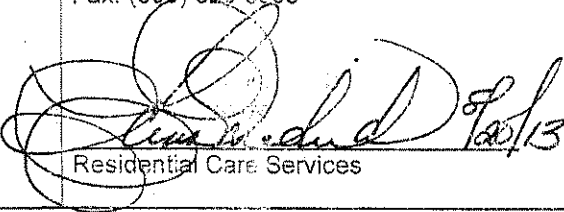


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/15/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW LUTHERAN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1841 EAST UPRIVER DRIVE SPOKANE, WA 99207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Riverview Lutheran Care Center on 8/15/13. A sample of 4 residents was selected from census of 60. The sample included 2 current residents and the records of 2 former and/or discharged residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>#2840994 #2825769 #2826547 #2817613</p> <p>The survey was conducted by:</p> <p> R.N.</p> <p>The surveyor is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit A 316 W Boone Avenue, Suite 170 Spokane, Washington 88201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p> Residential Care Services</p>	F 000	<p>Riverview Lutheran Care Center takes great pride in giving above and beyond quality care. Our number one priority is serving our residents and their families. We take each citation seriously and address concerns quickly and appropriately. We thank the survey team for working with us and helping us toward becoming a better nursing home for our current and future residents. We will continue to provide outstanding quality care.</p> <p>RECEIVED AUG 30 2013 DSHS ADISA RCS SPOKANE WA</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/15/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW LUTHERAN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1841 EAST UPRIVER DRIVE SPOKANE, WA 99207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement planned interventions to prevent falls for 1 of 4 sample residents (#2). The failed practice resulted in harm to the resident who fell and sustained a fracture. Findings include: Resident #2 had diagnoses that included [REDACTED] Per record review, the resident had a history of falls, was impulsive, and had recently experienced a decline in condition. Care planned interventions to prevent falls included supervision of the resident while in the bathroom and directed staff not to leave the resident alone. According to the record, on 7/9/13 the resident fell and sustained a fracture after staff left her unattended in the bathroom. The facility investigation of the incident determined staff was not following the care plan when the fall occurred. During an interview on 8/15/13 at 11:45 a.m., the resident stated she fell because, "There was nobody to help me off the toilet so I tried to do it myself." The resident further stated the fracture was very painful at first, but was getting better. The resident was observed wearing a protective splint on her left ankle.</p>	F 323	<p>F323</p> <p>The nursing home will correct this deficiency as it relates to this resident, and protect other residents in similar situations through initially educating and counseling staff directly involved. Further, re-in servicing all staff on resident safety specifically as it relates to toileting will occur. This in-service will include a zero tolerance approach for failure to follow Riverview's standard of care. To monitor our performance and to make certain solutions are sustained, the facility will continue to do random gait belt audits to ensure the safety of our residents. In addition, the facility will continue to do random care plan verbal testing of the direct care</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/15/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW LUTHERAN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1841 EAST UPRIVER DRIVE SPOKANE, WA 99207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 2 When interviewed on 8/15/13 at 1:10 p.m., administrative staff stated staff was expected to stay within reach of the resident when she was on the toilet and should not have left her unattended. The facility's failure to implement interventions to prevent accidents resulted in the resident falling and sustaining a significant injury.	F 323	staff to ensure correct knowledge of residents and individual safety needs. This corrective action will be completed by 9/16/13. The Director of Nursing will be responsible to ensure the correction.		